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SECTION OF LARYNGOLOGY. 4th Friday, monthly, 8.30 o'clock. Chairman, J. N. REIK, M.D.; Secretary, L. J. GOLDBACH, M.D.

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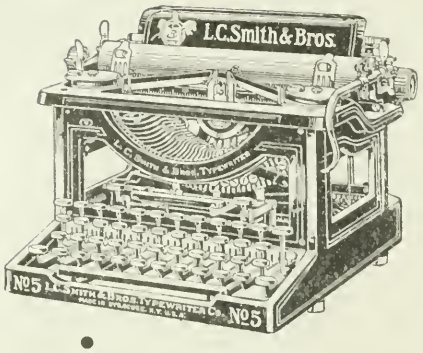

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THE NEED FOR GREATER ACCOMMODATIONS IN THE SYDENHAM HOSPITAL FOR INFECTIOUS DISEASES.

By John Ruhräh, M.D.

I HAVE been asked to speak for a few minutes on the subject of the need of greater accommodations in the Municipal Hospital for Infections, that is the Sydenham Hospital. To speak of the need of hospital accommodations sufficient to look after all cases of infections desiring or requiring hospital treatment in a city such as Baltimore, and before this audience, would seem at first thought to be entirely unnecessary, and yet when we compare the provision made by this community for this class of patients, and what is being done elsewhere, we see that Baltimore is sadly lacking. It will not be necessary to go into the reasons of why Baltimore has lagged so far behind other communities. They are, perhaps, not far to seek, but I wish at this time only to call your attention to the fact that the proper provision for caring for infectious diseases in hospitals should not be regarded as conferring a particular benefit upon the individual who receives the treatment. It should be considered in the light of a benefit conferred upon the entire community, for each case of an infectious disease acts as a focus from which new cases arise and every patient properly isolated means many less cases in the future.

It is an undoubted fact that hospital accommodations should be made for patients suffering from all classes of infectious diseases, but there are two diseases which more than all others need at this time to be considered. I refer to scarlet fever and to diphtheria. Both of these diseases, as you all know, are spread chiefly in two ways: first, by the direct infection of the individual from the patient suffering with the disease, and, secondly, by carriers those who retain in their bodies germs of the disease without actually having it or who retain them for unusually long periods after the attack. It needs no argument to make clear that if the

individual suffering with diphtheria and scarlet fever is isolated from the rest of the community there will be but few cases or carriers. I do not mean to say that the providing of a sufficient number of beds for these diseases would wipe out these two infections. It certainly would not, but it would lessen the number of cases tremendously.

After years of struggle Baltimore is provided with 36 beds, 18 of which may be used for diphtheria and 18 for scarlet fever. Sometimes an overwhelming number of one or other of the diseases makes it impracticable to care for more than one of the diseases at a time. In Baltimore, in 1912, there were 950 cases of scarlet fever and 1036 cases of diphtheria. In a certain proportion of these proper isolation could be carried out at home, but in the crowded homes of the poor and in the modern apartments the isolation of such dangerous infectious diseases is impossible. No provision whatever is made for the care of negro patients. When one considers that a very large proportion of the servants of this city are negroes, most of whom live in small, overcrowded houses, under the most unsanitary conditions, and that they go back and forth from their own homes, where there are frequently virulent infectious diseases, to the homes of the intelligent and educated citizens, where they are in close contact with the entire family, and especially the children, one cannot but wonder at the apathy of the average Baltimorean. It should be the duty of the health department to remove all such cases to a place where they would no longer be a danger to the community. This, of course, cannot be done unless the city provides adequate hospital accommodations for both white and black, and not only for the very poor, but for the well to do as well. There occur in Baltimore every year cases in boarding-houses, in hotels, in transit through the city, and the like, a great many cases of scarlet fever and diphtheria which tax to the utmost the ingenuity of those who have to deal with them. There is, with the exception of the meager accommodations to which I have referred, absolutely no place in which these patients can be cared for and they are thrown upon the charity of friends or strangers.

In 1904 Dr. Rosa Engelmann of Chicago secured information concerning hospital facilities for the care of diphtheria and other contagious diseases from 25 of the largest cities in the United States. In most of these cities more or less adequate provision was made for the isolation of smallpox, just as Baltimore makes ample provision for the isolation in care of persons with this disease, but when it comes to other infections, which are a constant menace and which actually do much more damage than smallpox, it was found that 10 of the cities made no provision whatever for the care of infectious diseases, and there were only three cities which had more than 100 beds and only five cities with more than 55.

Engelmann speaks of Baltimore as follows: "The foremost university town in the country, and a great shipping port, and abso-

lutely no provision for what I hardly consider the minor infectious diseases, upon which millions of dollars each year are spent in their care rather than in their prevention." The whole question with regard to the care of these common infectious diseases is so out of harmony with our knowledge on the subject that it seems truly strange that more is not done in this direction.

In New York city there are at present approximately 1800 beds for contagious diseases, and inside of a few months a sufficient number will be added to make the number over 2000. With a population estimated at 5,000,000, this is in proportion to one bed to 2500 of the population. The Philadelphia Hospital for Contagious Diseases at present has a capacity of 180 beds for scarlet fever and 80 beds for diphtheria. When the hospital is completed it will have a capacity of 300 beds for scarlet fever and 200 beds for diphtheria. During the winter just past as many as 400 scarlet fever patients and 130 diphtheria patients were cared for in the Philadelphia Hospital at the same time. Philadelphia's estimated mid-year population for 1913 is 1,631,000. In the year 1912 62 per cent. of all cases of scarlet fever and diphtheria (scarlet fever, 2872, and diphtheria, 3082 cases) reported were taken to the Hospital for Contagious Diseases. The Philadelphia Health Department would like to take care of at the hospital at least 90 per cent. of all cases of scarlet fever and diphtheria.

In Boston there is accommodation for 120 diphtheria cases, 120 scarlet fever cases and 60 measles cases. Owing to the large number of patients needing care, these numbers are frequently exceeded so that the hospital is crowded beyond the normal limit. This gives an accommodation in Boston for three out of every 10,000 of the population, that is about one infectious bed for every 3300 inhabitants.

The question as to what would represent a sufficient number of beds for the acute infectious diseases may be answered by the experience of the English and Scotch cities. In Glasgow, in Edinburgh and in London there are accommodations for nine out of every 10,000 of the population, and this may be taken as the minimum number of beds that will care for the infectious diseases in anything like a satisfactory manner. The ratio of one bed to each thousand inhabitants would be still better and certainly ought not to represent an impossibly large investment for any city when one considers the great good that can be accomplished with a comparatively small amount of money. The ideal would probably represent hospital accommodations for one out of every thousand inhabitants with sufficient temporary accommodations to care for any epidemic of unusual severity. The whole question of the care and management of a municipal infectious disease hospital is one in which our knowledge is undergoing very radical and important phases. This part of the subject cannot be considered at this time, the main point is to emphasize the careless attitude taken toward the infectious diseases at the present time by the inhabitants of Baltimore.

FIBROIDS AND PREGNANCY—THREE CASES.

By William S. Gardner, M. D.
Professor of Gynecology, College of Physicians and Surgeons, Baltimore.

The incidence of pregnancy and uterine fibromyomata is not rare, but in the vast majority of the cases the tumor is in the upper part of the uterus and is subperitoneal. Fibroids in this location, unless very large, have little or no influence on either pregnancy or labor. When, however, the growth is from the lower segment of the body or from the cervix the condition becomes a serious menace both to the mother and to the child.

An absolute essential to the proper management of these cases is the early recognition of the condition so that all complications may be anticipated and prepared for.

Occasionally a fibroid develops in such a position and becomes of such size as to make it at least highly improbable if not actually impossible for the pregnancy to go to full term. When this occurs it is the duty of the attendant to act first and by removing the tumor give the pregnancy its best chance for development and maturity. This variety is illustrated by case A.

Case A, 1190, was admitted to Mercy Hospital January 30, 1908, aged 38. She has had two children, the last one nine years ago. The last menstrual period was November 25, 1907. Since the last pregnancy, nine years ago, the flow has been regular but scanty, continuing only one day. There was some pain for one day. Bowels constipated, urination normal.

She first noticed a lump in the lower abdomen three years ago. It apparently did not increase in size and gave very little discomfort, except when she was much on her feet. During the past two months the growth has increased in size rapidly, and she has been greatly annoyed by pulsations in it.

On physical examination the heart and lungs were found normal. The abdomen was somewhat distended with a distinct protuberance below the umbilicus. There was dullness on percussion from the umbilicus to the pubis. A large, hard, movable mass could be felt filling up the lower abdomen. By the vagina the cervix was found turned upward toward the symphysis; the tumor was attached to the uterus anteriorly; beneath the tumor, lying in the hollow of the sacrum, was the enlarged, cystic, pregnant uterus.

Diagnosis: Retroverted, pregnant uterus complicated by a large fibroid.

The first question that came up was: Can this woman, unassisted, go to full term? This was answered in the negative, because it seemed entirely impossible to conceive of this tumor, which was rapidly enlarging and already reaching the umbilicus, being pushed high enough and far enough forward to allow the retro-

verted uterus to escape from beneath the promontory of the sacrum and develop in the abdomen. In my judgment the immediate removal of the tumor was less hazardous to both the mother and the child than anything that might be hoped for from delay. Consequently the patient was advised to have an operation done at once for the removal of the fibroid. She was told that the operation might produce a miscarriage; but that on the other hand the probability of going to full term in her present condition was practically nil.

Operation, February 3, 1908. The abdomen was opened in the median line below the umbilicus. The tumor had the peritoneum stretched loosely over it in such a manner that the site of the attachment to the uterus could not be seen. After the peritoneum was stripped off a very short but relatively narrow pedicle was seen connecting the tumor with the uterus near the junction of the body with the cervix. The pedicle was cut through and the hemorrhage from it controlled by a number of catgut mattress sutures. The peritoneum was brought together over the stump, the uterus raised to the proper position and the abdomen closed.

The convalescence from the operation was uneventful. She left the hospital February 25.

In August, 1908, her physician wrote me: "Mrs. M. gave birth to a nine-pound boy July 27th. It was an easy and normal birth; both mother and child are doing splendidly."

The tumor removed was an ovoid fibromyoma, measuring fifteen by sixteen centimeters.

When a fibroid is in such a position that it absolutely obstructs the pelvic canal it may still be where it does not interfere with the development of the pregnant uterus. When a case of this kind has gone to full term it is folly to allow the woman to become exhausted in labor by efforts that can result in nothing but damage. And under the same conditions attempts to use forceps, version and all such aids as are useful in moderate dystocia are contraindicated and far more fruitful of harm than of good. The conservative operation here is Caesarean section. This type of cases is illustrated by Case B.

Case B, 4590, aged 30, was admitted to Mercy Hospital February 24, 1911. The present was her first pregnancy. The last menstrual period was May 19, 1910. Before that her periods had been regular and the flow continued seven or eight days. She had been under observation for several months, and her general health was excellent.

Some time in the latter part of the summer of 1910 I was asked by her physician to see her with him. He told me that she was pregnant and that she had a fibroid that almost filled the true pelvis. My own examination only confirmed this diagnosis. It was clear that delivery by the ordinary route would not be possible. We decided at that time to deliver her by Caesarean section when

the full term of pregnancy would be complete, and which we estimated would be February 25th, 1911.

She entered the hospital February 24 and the operation was set for 9 o'clock the next morning. Early on the following morning labor pains set in and the bag of waters ruptured. Immediate preparation for operation was made and carried out two hours ahead of the scheduled time.

The abdomen was opened, the uterus incised and the child and placenta removed. A hysterectomy was then done in just the same manner as if a Caesarean section had not been made.

The child weighed nine pounds, and both it and the mother left the hospital in excellent condition March 18th.

This case differed from the one first related in that in this instance the developing uterine body was in the abdomen above the fibroid and there was nothing to obstruct its development. The size and position of the tumor, however, absolutely obstructed the birth canal and made a suprapubic delivery necessary. In the first case the uterus was retroverted and the large fibroid was on top of it, jamming it deeper into the pelvis. It was not in a position to interfere with delivery, but was in a position to almost certainly interrupt the pregnancy.

The third case differs from both the others. In this instance the fibroid was located in the lower segment of the posterior uterine wall, and on account of its position gave rise to much apprehension, but no positive trouble. It belongs to the borderline cases. One that only a slight variation of size or position of the tumor might call for as radical treatment as case B.

Case C, 1823. About the year 1900 this patient had a ventrosuspension done for a retrodisplacement of the uterus.

I saw her for the first time September 2, 1910. She was then aged 35, married, and had never been pregnant. The appetite was good; the bowels constipated; micturition frequent, but not painful.

The last menstrual period occurred August 16; twenty-eight-day periods; the flow continues from seven to ten days very profusely; no dysmenorrhoea.

One week before each menstrual period there is a severe, recurrent pain in the pelvis, which lasts for five or ten minutes. There has been much backache for the past week. She becomes very nervous when lying down, and cannot lie upon her back.

On physical examination the uterus was found retroverted and very much enlarged.

She entered Mercy Hospital September 8, and the following day the abdomen was opened and a submucous fibroid was removed through the anterior uterine wall and a round ligament suspension of the uterus was done. Search was made for other fibroids, but none were detected. From this operation the recovery was uneventful, and she left the hospital September 23, 1910.

In June, 1911, she had an early miscarriage. At this time it was

discovered that a small fibroid had developed in the lower portion of segment of the uterus. Its growth had been stimulated by the pregnancy. The patient refused to have the fibroid removed.

In September, 1911, she again became pregnant. The little fibroid, which could not be felt or seen in 1910, having been stimulated in its growth by the first pregnancy, during the progress of the second pregnancy increased in size rapidly. About the time during the first half of the pregnancy the tumor could be palpated easily through the posterior vaginal wall. It was within the true pelvis and was sufficiently large to offer a great obstruction to labor if it remained in that position. Fortunately, as the uterus increased in size the fibroid was raised above the brim of the pelvis. This position of the fibroid was so much more favorable than had been hoped for that we believed that labor could terminate naturally. Being fearful that when the labor began the tumor might be pushed down into the pelvis, she was sent to the hospital just before the completion of the term of pregnancy in order that we could take immediate action for the relief of any complications arising during labor.

She was delivered perfectly normally July 12, 1912.

6 West Preston street.

SOME PHYSICAL EFFECTS OF INDUSTRY UPON THE WORKING CHILDREN OF MARYLAND.

By J. C. Travers, M. D.

One of the most significant and important features of our work as medical examiners of the Maryland Bureau of Statistics and Information has been the finding and isolation of the diseases and defects of occupation among the working children of our city and State. The diseases incident to child labor are, comparatively speaking, in a class to themselves, due chiefly to the susceptibility of the undeveloped child, whose physical stamina is weak and whose power of resistance much less than that of the mature adult, and whose mind being less active and alert and the judgment immature, renders it less likely to protect itself when engaged in hazardous or dangerous works.

The exploitation of child labor is a harrowing story and one of the dark spots on the page of the industrial history of our country. The advent of the great variety of special machinery and unskilled methods of manufacture, as well as parental greed and poverty, and the encouragement of employers called into action a growing army of youthful workers. The drawbacks to child labors are that children are deprived of leisure and freedom in the open air and are subjected to a monotonous life when they ought to have variety. The physical effects outside of the diseases incident

to trade are those of degeneracy, as seen in stunted growth and impaired nutrition; while of the moral effects, illiteracy and its consequences are the more immediately apparent. Factory legislation in this country as abroad, began with the curtailment of women and children's labor, shortening of the hours and the improvement of the conditions under which labor generally is carried on. As modern industrial and economic conditions demand cheap unskilled child labor, it is imperative that our duty is to render this labor as little injurious as possible, and so administer as to protect and conserve the industrial life and general welfare of our nation's children. The industrial physical condition of the child, as of the adult worker, is peculiar to the locality, the climate, the race, and the temperament, as well as the characteristic industries of the locality. There is probably no city in the country that embraces more varied or complicated kinds of industries than Baltimore. Here we have factories for the manufacture of every kind of commodity and such as to allow the employment of the unskilled child laborer in great numbers, with no adequate factory inspection or regulation to protect them. No person should be employed in a dangerous trade until the risks have been explained to him by the employers and decided means taken whereby danger in health may be averted.

The chief conditions met with in our factories, as elsewhere, as tending towards industrial disease, are imperfect ventilation, absence of means for the withdrawal of dust, imperfect supervision of the workers and inadequate washing appliances. Want of cleanliness has long been recognized as an important contributing factor, especially when combined with poverty, deficient food and clothing and improper housing; but these are economic and social conditons and problems which travel hand in hand with our industrial life. Of the children engaged in factory work in Baltimore, all being over 14 years of age, we have succeeded in isolating nearly 100 diseases and defects due to occupations. This data represents the findings out of about 1500 factory children examined and is limited chiefly to about 12 principal industries. In our occupational disease findings we have not included that large number of children suffering with asthenopia or eye strain due to the overuse of tender eye muscles in improper light and the constant alertness required in the manipulation of machinery or intricate work. There are a large number of these cases and they furnish by far the largest class of occupational defects. For example, we find among the children just beginning work less than 5 per cent. of defective vision and eye strain, where as among the children long employed in factories the percentage ran as high as 10 per cent. to even during one month 20 per cent. The most numerous diseases found were those conditions due to the inhalation of dust, which is the greatest enemy of the factory worker. Of the 100 cases, 28 were found to have irritation or inflammation of the respiratory passages, such as rhinitis, laryngitis and

bronchitis, among such boys as engaged in sandpapering, wood-work being an inorganic dust irritant, or metallic dust such as inhaled by tin workers, and chemical dust breathed by the children engaged in bronze works. Bronze workers frequently present a pharyngeal vault completely gilded. This dust would also get in the hair and clothing, irritate the scalp and produce severe dermatitis. Another harmful dust to these children was also a chemical or mineral dust. Children, both girls and boys, being engaged in filling bottles with yeast powder, the dust of this process was very profuse and set up bronchial irritations, besides producing a toxic effect with symptoms of neuralgia, nausea, gastric pain. Their hair would fall out and many of them become pale and weak. Cotton, hair and broom fiber were the chief offending factors among the organic dust workers. In the boys employed in the cotton mills we found the most severe form of bronchial irritation, and one case of cotton fibroid phthisis. Of the diseases due to fumes of chemical or mineral irritants and poisons the most notable was among the boys employed in washing copper; here, out of 8 boys examined, 4 were found to have ulcers of the nasal septum and sore eyes, with eventually atrophy of the nasopharyngeal mucous membrane and soft structures, due to irritant and caustic properties of the acid and mineral-laden atmosphere of which they breathed. We also noted a similar condition in several boys employed in the tin and enamel works, where there existed practically the same irritant atmosphere as the copper works; fumes of HCl and zinc chloride, lead and dust formed the principal atmospheric irritants and poisons. One boy working adjacent to solder workers presented symptoms of solder poison, which is about the same as acute lead poison, plus nasal irritation. Working in enamel is a very dangerous occupation on account of the presence of lead; also block tin, which contains as high as 60% of lead. Quite a large number of children were affected by various forms of organic chemical toxins, complaining as a rule of headache, nausea and vomiting, gastric pains, weakness and were pale and anemic. These conditons were found principally among children employed in handling freshly made window shades; inhaling fumes of oils, quick dryers, such as turpentine or benzine, alcohol and organic or aniline stains or coloring used in their manufacture. A few cases of toxic amblyopia were also noted among these workers. Then again in boys working adjacent to varnishers and stainers in chair and furniture factories, there are also prevalent fumes of turpentine gums and inorganic colorings and lead. Children employed in making buttons composed of hot fuming horn tissue, the fumes of this tissue together with the steady heat produced quite an intense form of toxemia in a number of these children. A similar condition was detected among several children working in the hair brush and broom factories through the inhalation of fumes of decayed hair and broom corn. Boys and girls employed in candy factories making chocolates

and candy were likewise occasionally affected through the inhalation of the fumes of hot candy, glucose, sugar, flavorings, the latter two probably being coal tar derivatives, also constant heat; these affected children, in addition to the usual symptoms of toxemia, nausea, vomiting, tremor, etc. They complained of dizziness and faintness; the skin was cold and clammy, and they became weak and nervous. Probably the next defects of importance were among the children suffering from myalgias, or muscular strains, due to the effect of carrying heavy loads; heavy work and the heavy straining character of their work. We find these sufferers employed in the various clothing factories carrying heavy bundles of clothing, carrying and lifting boards and boxes in the box factories and in packing tin cans in canneries; the latter suffered with stiff and sore backs and arms; several workers also developed arch troubles due to long standing on weak undeveloped feet and legs.

Of the most serious defects found was that of two boys who developed serious heart disease or defects due to their being compelled to walk or run long distances while delivering messages for a messenger service company. The physical strain on the heart caused by the excessive exercise proved too great and resulted in cardiac hypertrophy, dilatation and insufficiency. Our experience has taught us to believe that the great number of the cases of myopia which we find in these children almost daily is due to the result of occupations, by performing constant near work under bright electric lights. Another great class of occupational defects of which the number is legion among these youthful workers is the various forms of fatigue or occupational neuroses, where the long hours, the heavy strain of labor upon young undeveloped bodies and nerves, especially before the completion of puberty, and the nerve energy spent in constant alertness incident to the working of machines, some of them intricate and dangerous, results in a disorganization of the nervous system with its long train of nervous symptoms and a picture of a pale, haggard child. These conditions are naturally more prevalent among girls than boys, but due to the anxiety of the working child to procure a working permit, and the craft they employ in covering their physical defects it is hard to procure reliable data. On the completion of the physical resurvey of the children employed in factories, we will be in a better position to furnish more complete and reliable data concerning industrial anomalies, judging from what we have seen and found during a year spent in this work, we see most clearly the importance and the necessity of a more thorough study, control and correction of the general industrial and factory labor. This to my mind can best be brought about by the creation of a State Industrial Commission and a properly organized and equipped medical force under the control of the State Department of Health, with arbitrary powers to deal with all the great problems of industrial life. Then we can reasonably ex-

pect through the evolution of industrial chemistry and hygiene, the making of great strides toward the prevention and obliteration of occupational maladies and mishaps, and the protection of the general welfare of the most neglected and numerous of the world's workers.

The following is a summary of the occupational defects found during the past six months from the re-examination of about 1,500 boys employed principally in factories:

2 cases chronic copper poison.
2 cases acute copper poison.
2 cases occupational cardiac disease (organic) from excessive strain due to over-exertion in running and walking.
1 case nasal ulcers from chemical irritants.
2 cases nasopharyngeal ulcers and inflammation from chemical fumes.
9 cases acute occupational pharyngitis and bronchitis from inorganic dust.
3 cases occupational dermatitis, local action of chemicals and irritants.
3 cases occupational anemia.
4 cases tobacco pharnygitis and nicotine toxemia—from dust and fumes of tobacco.
4 cases progressive myopia—accelerated by occupation.
14 cases nasopharyngeal and bronchial irritation from organic dust and fumes.
12 cases toxemia or poison from organic chemical fumes.
4 cases occupational and fatigue neuroses.
1 case hypertrophic rhinitis from organic fiber dust.
3 cases toxemia or poison from inorganic fumes and chemicals and dust.
1 case occupational, chronic bronchitis from constant dampness in canneries.
2 cases subacute bronchitis from chemical fumes.
17 cases ocupational myalgias, muscular strain, cramp and soreness.
1 case pedal workers' cramp (button factory).
1 case doffers' cramp (cotton duck mill).
1 case acute toxic amblyopia from organic chemical fumes.
1 case solder poison from fumes of solder.
1 case toxemia from inhalation of fumes of wood alcohol.
1 case fibroid phthisis (cotton duck mill).
1 case acute lead poison (chair factory).
1 case severe laceration hand (left), stiff and sore, by tin printing machine.
6 cases severe burns on face and hands from hot wax.
1 case laceration of eye (cornea) by knife, coring apples, causing complete blindness and affecting sight of other eye.

1 case infected hands from burns.
1 case asphyxia, buried under cork.
20 cases lacerated, mashed, sore or inflamed hands and arms, chiefly from sharp tin, running machines, saws, handling tin cans.
8 cases irritated and sore hands from handling chemicals.

SYMPTOMATOLOGY OF CEREBRAL ABSCESS.*

By *Charles W. Richardson,*
Washington, D. C.

The symptoms of cerebral abscess is a somewhat complex one, varying in character according as we view them from its inception, during its period of latency, with evidence of intracranial pressure, or during its terminal stage. To take up the consideration of the subject in its various stages would occupy too much of your valuable time, therefore I shall attempt to discuss the symptoms as manifested from the late formative period through that of latency, during the time when they are usually brought under our observation, and in the period when the early diagnosis correctly made counts so much for the possible future welfare of the patient. Indeed, unless the patient is already under our observation, we rarely see them at the onset of the cerebral complication. With a patient under our immediate observation affected with an acute or chronic suppuration from the middle ear, who has a chill, severe headache, with possible nausea and vomiting which subsides within a few days, and the patient assumes a nearly normal condition, excepting as to the head pain, many of us would become suspicious of an intra-cranial complication and watch intently for the development of those more impressive and exact symptoms which will lead us to the correct definition of the nature of the invasion.

Trite as it may seem in addressing a meeting of otologists, I should suggest a thorough and careful examination of both ears as the preliminary procedure in elucidating the condition of a suspect of intra-cranial lesion. The condition of the canals, the presence of exudate and its character, the making of smears and cultures, the amount of destruction of membrane and the location of perforation, and careful investigation as to the existence of fistula, may be, and usually is, of material assistance in clearing up the diagnosis, not only as to the character of the case, but also of the probable location of the lesion. The mastoid region should also be carefully examined and palpated. The blood should be examined as to the existence or non-existence of leucocytosis.

One of the earliest and most constant symptoms of cerebral abscess is headache. In the few cases that have come under my

*Read at the meeting of the Baltimore City Medical Society, January 21, 1914.

observation I have never found it wanting. It is not usually as constantly and increasingly severe as the head pain in leptomeningitis, but is quite as constantly present. It is present in a subacute form in the initial stage, mildly present in the latent stage, and again occasionally severe in the terminal stage. In the acute stage the pain is frequently very intense in the fundus of the ear. Persistent head pain or continuous severe ear pain occurring in any case of suppurative otitis should arouse the suspicion of intracranial complication. Whatever the degree of the pain of the brain abscess, whether severe or simply of the dull boring type, it has one distinguishing feature in that it keeps the patient awake at night. The pain of cerebral abscess is usually unilateral, limited to the side of the head corresponding to the hemisphere affected and is generally localized. It is most frequently frontal, sometimes temporal or over the affected ear, very occasionally occipital. Pressure over the seat of pain occasionally—and percussion over the same area—frequently intensify the pain. Coughing and vomiting intensify the head pain.

Mental symptoms are manifested in some form in most cases of cerebral abscess, and, where one knows the habits of the patient and his temperament, they may be noted quite early in the life of the case. Alteration of temperament is noted quite early in many cases, usually in the form of irritation. Hallucination, irritability of temper, restlessness, boisterousness and confusion of thought are more or less present in most cases. Rarely somnambulistic phenomena are manifested. In one of my early cases of cerebral abscess this condition was present. Occasionally the mental disturbance manifests itself in the form of apprehension, apathy or depression. In a little boy, upon whom I successfully operated, the state of apprehension was the first symptom that attracted my attention to the seriousness of his condition. In all cases in the latter period of the latent stage there is a marked slowing of thought and sluggishness of mental action. The slowness of the mental act is quite pronounced in practically all cases just before the terminal symptoms become manifest. A patient in this state is usually inclined to be quiet, frequently drowsy, and not inclined voluntarily to enter into conversation. They usually have a semi-doped appearance, or move about in a dazed, restless manner. If directly questioned they frequently become alert and readily answer any given question, but immediately lapse into the same taciturn manner. When the stage is more marked they will attempt to answer questions, but do so very slowly and usually after a pause, or may answer only a part of the question asked, and then seemingly drop off into a drowsy state again. The time occupied by a patient in replying to a question may seemingly cause the questioner to doubt whether he has heard or understood it, when at last, to his relief, the patient slowly but accurately gives reply. Also, the patient may have a failure in the power of sustained attention, a partial inability to concentrate his attention on any

given theme but for a few moments. For this reason he may be able only to respond intelligently to the simplest questions, or, wishing to communicate some thought, he may begin to express himself and desist after uttering a few words, may express a wish for some object and not remember the desire when the object is brought.

Insomnia during the latent period, especially if the head pain is marked, is a very noticeable symptom. Even when the headache is not marked the patient may be practically sleepless during the greater period of the twenty-four hours. What little sleep they get is fitful, and they arise in the morning from an unrefreshed slumber. Even though drowsy during the daytime, they may be wakeful through the night.

The temperature reading varies according to the stage of the abscess, but is never of a very active type. During the formative period it may rise as high as 102 degrees, from which it drops to about the normal in a very short interval.

The temperature variation is very slight after the initial rise and fall until the terminal stage is reached. The excursion of the temperature during the day is very slight; it is not unusual to have either a normal or a moderate sub-normal temperature. A temperature varying from a degree below normal to a degree above normal, with other suspicious evidences of intra-cranial involvement, should be looked upon as a strong corroborative evidence of the existence of brain abscess in a given case. A normal or sub-normal temperature is more likely to be present with a deep-seated abscess, while a moderately elevated temperature is more likely to prevail with a cortically-placed abscess. The pulse is of undoubted significance in suspected brain abscess. The pulse rate, like unto the temperature range, is rather inclined to assume a sub-normal rate. Primarily increased in activity in the initial period, the pulse rate in a typical case is gradually retarded until the beats may be reduced to 50 or 40 to the minute. With the onset of the terminal stage the pulse rate usually becomes accelerated.

The respiration may or may not be affected in cerebral abscess. When affected it tends to become abnormally slow, in some cases irregular.

The evidences on the part of the digestive system may or may not be pronounced. Vomiting occurs in a fair proportion of cases. It is very rarely absent in the initial stage. Dench states that it occurs in about 50 per cent. of all cases and is an important diagnostic sign in the initial and terminal stages of brain abscess. Dercum states that it is quite common, but may be only slightly pronounced. Vomiting has not been present in most of the cases which have come under my observation. The tongue is coated, the breath foul, and the bowels constipated.

The general symptoms are usually shown by the evidence of marked illness, as depicted by the patient's appearance and facial expression. The face has an ill, anxious and haggard expression

and is pale or sallow. When the progress of the [illegible] there is more or less loss of flesh and strength. This condition is probably brought about partially through septic and partially through trophic changes. Rigors are not usually present in cerebral abscess, and a case may run its whole course without chill or chilly sensation. Shivering may be present, and, when manifested, it is in the form of cold creeps running over various portions of the body surface.

Changes in the eye ground in the form of choked disk or optic neuritis is an occasional concomitant symptom of cerebral abscess. It is stated to occur in about 40 per cent. of cases. The eye ground should always be examined in suspected intracranial cases for manifestations of changes in the optic disk. Papillitis is more frequently seen in cerebral abscess than optic neuritis, as the rapid development of an abscess does not permit, through the shortness of time, the production of a well-marked neuritis. A papillitis, or optic neuritis, may develop in one or both eyes, and, as it may occur in a right eye with left-sided cerebral lesion, or vice-versa, it cannot be classed as focal or localizing symptoms, and are, on the whole, simply corroborating symptoms of an existing intracranial disturbance. The existence of an absolutely normal eye ground in no wise negatives the existence of a cerebral abscess. Photophobia may be present. The pupillary reaction may or may not be affected, depending in greater measure upon the size, location and the degree of pressure disturbance created. Pupillary changes are usually manifested in the eye upon the side corresponding to the hemisphere in which the cerebral abscess is located. The pupil may be contracted or dilated, or simply show sluggishness of action as compared with its fellow.

Motion changes are not pronounced in cerebral abscess and do not develop until a late stage, although it is not invariable. In some cases, with large cerebral abscesses, we may note a moderate degree of contralateral paresis, especially involving the upper extremity. Indeed, the degree of paresis is so moderate as would escape notice unless investigation is made as to the degree of action of the muscle upon the two sides. The gripping of the hands or the use of the dynamometer will reveal the inequality.

Muscular spasm affecting groups of muscles to general convulsion may be present in otitic cerebral abscess, but are rather rare except in rapidly-forming and large abscesses in the temporal lobe, or when a chronic abscess takes on an acute extension, thus causing pressure on the lower part of the prae-central loble; or an abscess in which there is a limited tendency to the formation of a limiting capsule, with the development of surrounding encephalitis, which latter may extend into the motor areas of the frontal lobe. In two cases of general convulsion, with complete unconsciousness, into which I was brought in order to aid in clearing up the diagnosis, I found evidence of chronic suppuration, with foul-smelling pus. In one case there was a history of suppuration;

in the other there was a negative history, but examination, made with difficulty, proved the existence of a small pin perforation, with a meager amount of ill-smelling pus in the auditory canal. Both cases, even though unconscious, showed sensitiveness to pressure over mastoid of affected ear.

Paralytic phenomena of a general character are rather unusual in cerebral abscess. As the abscess is usually without the motor area, focal symptoms are not common. Paralysis, when occurring, is usually the result of the extension of the abscess, with the attending destruction of a given motor area; or, in partially demarkated abscess, to the zone of encephalitis, which surrounds it and extends into the motor area affected. Such conditions might also be due to secondary abscess or to a small-sized abscess involving the internal capsule. A type of paralysis which is described, although I have never seen such a case in cerebral abscess, is a contralateral hemiplegia with a paralysis of the third nerve.

One of the most characteristic symptoms of cerebral abscess, when manifested, is the presence of aphasia in one of its varied forms. Aphasia is only present when a left-sided lesion occurs in a right-handed patient, and vice versa. The type of aphasia which occurs most frequently in otitic cerebral abscess is the form which is known as sensory aphasia or word deafness. The cytological examination of the blood is not of positive diagnostic value. When the polymorphonuclear percentage is increased above the normal, the case should be looked upon with suspicion.

Lumbar puncture appears to be of the same value as the blood count. Those cases presenting a normal appearing cerebro-spinal fluid which is stenile are more favorable as to prognosis.

The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. October, 1913. Philadelphia and London: W. B. Saunders Company. $8 per year. Volume II, Number 5.

Volumne two, number five, of Murphy's Clinics contains a wide range of subjects, namely, Tumor of Femur; Cavity Filled with Moorhof Wax; Ankylosis of Hip Following Sore Throat; metastatic arthritis; arthroplasty, abdominal fecal fistula following puncture of the uterus by curet and drainage of retro-uterine abscess; remarks on use of curet; resection of bowel; end to side suture; anastamosis; sarcoma of the thymus gland, etc.

In this volume Dr. E. Wyllys Andrews tersely elucidates his method of herniotomy. This article is illustrated. It is impossible to pick any article specially for lengthy remarks, as each and every one contained in the number is of interest to the surgeon as well as general practitioner. You cannot open the book any place without seeing something of value, let alone practical utility. Like its predecessors, it is chock full of valuable suggestions. Suggestions that tend to simplify the surgeon's work.

THE EARLY RECOGNITION AND THE PRACTICAL PREVENTION OF UTERINE CANCER.*

By H. S. Smith, M.D.
Baltimore, Md.

A CAREFUL estimate places the number of deaths from cancer in the United States at 80,000 annually—enough to depopulate the city of Baltimore in a very few years. When we consider the relation of our own population to that of the entire world, and think also of the number of cases that are cured, not to speak of those persons who are erroneously reported to have died from some other cause, we can begin to form an idea of the appalling prevalence of this scourge, which is worldwide in its devastations. Of the number of deaths mentioned it is said that at least one-half could be prevented by an early diagnosis. If this statement be even approximately correct, it seems unfortunate that so much money and thought and energy should have been expended in a fruitless search for the essential cause of cancer, while so little has been done to elaborate methods for its earlier recognition, to study the clinical facts in regard to it, and to treat in a practical manner the great problem which it presents. Recently, however, the plan of attack has been along the lines of which I have spoken and scientists and laboratory workers are earnestly searching for the much-coveted diagnostic key, practicing physicians everywhere are discussing the subject from a clinical point of view, and organizations and philanthropists are busying themselves with *conditions* which need amelioration as well as *theories* which need support.

It is my purpose tonight to speak only of cancer of the cervix uteri, and to present briefly some of the signs and symptoms which may be utilized with advantage in dealing with it in its early and curable stage. First, as to the symptoms. These may be given in a general way as pain, hemorrhage and discharge. It is constantly to be borne in mind, however, that there is no symptom of cervical cancer which is present in all cases, and, in some instances, all the ordinary symptoms may be absent until the inoperable stage has been reached. This fact is one of great practical importance and gives great emphasis to the necessity of a physical examination in all cases in which there is the slightest suspicion of malignancy.

Of the symptoms which I have mentioned, hemorrhage is by far the most important and the most ominous. It may first appear as a prolongation of the regular menstrual period, or as a slight bleeding in the menstrual interval, in the form of a spot of blood upon the clothing or a slight streak in the leucorrheal flow. This

*An Address delivered before the Franklin Square Hospital Medical Association, February 3, 1914.

apparently insignificant intermenstrual hemorrhage is said to come from the capillaries in the mucosa which overlies a cancerous nodule or from the diseased tissue itself, and is particularly apt to follow any kind of irritation or pressure upon the affected parts, such, for example, as that caused by long walking, straining at stool and sexual intercourse. In cases where the menopause is supposed to have been passed, the hemorrhage of cancer is frequently regarded with complacency, if not with satisfaction, because it is thought to indicate a re-establishment of the menstrual function. The secret of many delayed cases of cancer lies in this belief, which has hitherto had wide acceptance among women. All the forms of hemorrhage to which I have referred, in a woman between 35 and 60, furnish a sufficient reason for a careful physical examination.

Leucorrhea may be present before there has been any pain or hemorrhage, and some surgeons have placed great reliance upon certain so-called distinctive features of the flow as it is seen in the early stage of cancer. It seems, however, to be an ordinary cervical leucorrhea, the amount of which has been increased by the irritated and overactive cervical glands. I do not think there is anything characteristic about it as an index of the disease in its curable and incipient stage.

Pain, as one of the criteria of early cervical carcinoma, has little or no value. The cervix, as we all know, is comparatively insensitive, and, until the disease has invaded contiguous structures, practically no suffering is, as a rule, complained of. Such invasion having taken place, the location, character and intensity of pain will be determined by the particular structures directly affected or pressed upon by the cancerous growth. Favorite seats of referred or reflected pain are the sacral region of the back, the ovaries, the rectum and the thighs.

The symptoms which I have enumerated are those which are most common in cancer cases, but, as I have said, none of them is in any way characteristic or pathognomonic of the disease. If so, no examination would be necessary. It is, therefore, worthy of repetition that in women of the so-called cancer age no indication, however slight, of the possible existence of cancer should be lightly regarded. Expectancy and therapeutic nihilism find here no possible justification. Duty demands action, and the proper action should be a thorough physical examination, followed, if necessary, by a prompt resort to the microscope.

The physical signs elicited by such examination are of great value. They will depend, of course, upon the location of the epithelial cells in which the disease originates and the direction in which it grows. Cancer of the vaginal portion—the squamous-cell carcinoma—frequently begins upon the site of an inflammatory erosion which has followed an old cervical tear. The beginning of the transition from the benign to the malignant cannot be demonstrated except with the aid of the microscope. A little later, when disintegration of tissue has begun or the cancer has

assumed the so-called vegetating or papillary form the existing ulcer or the polypoid mass does become demonstrable by the unaided senses. Before this has occurred, however, it is to be noted that the suspected area bleeds more easily upon being touched than does the simple inflammatory area, and may be noticeably elevated above the surrounding tissue. Careful palpation of its margins may also disclose an indurated edge, while the submucous portion of the cervix is peculiarly dense and hard. When a decided ulcer is found, these characteristics are of course much more marked. The very presence of such an ulcer, or indeed, of any ulcer, is strongly indicative of malignancy, since we know that benign ulcer of the cervix is extremely rare. The polypoid masses to which I have referred may be found as wart-like growths or eminences which are peculiar in their friability and the readiness with which they bleed upon even the gentlest manipulation.

The most insidious form of cervical cancer is that in which the disease begins in the cylindrical epithelium of the cervical canal. Fortunately, this is relatively uncommon, for in it extensive destruction of tissue may take place without any evidence upon the exposed surfaces. Of course, where there has been a bilateral tear with eversion of the mucosa, this form is more quickly recognized.

Beginning in the mucous membrane of the cervical glands, cancer very commonly appears in the form of nodules in the substance of the cervix. These require to be differentiated from the so-called Nabothian cysts which are so frequently seen in connection with lacerations and are referred to as cystic degeneration of the cervix. The exclusion of such cysts is easy, both by their appearance when they project beyond the surface, and by the simple expedient of puncturing them, when the characteristic mucilaginous contents will become evident. An interesting point in connection with these cancerous nodules is that the mucous membrane which overlies them is not alone congested, but upon palpation it seems glued to the structures beneath and does not glide readily over them, as in the normal and in benign conditions. This is an extremely suggestive sign, and is, I take it, analagous to the retraction and dimpling of the skin, which furnish so valuable a diagnostic guide in cases of cancer of the breast.

In all forms of cervical cancer there is a general induration of the tissue, the normal resiliency and elasticity of which are practically lost. This gives not only a useful palpatory sign, but it is peculiarly noticeable when an attempt is made at dilatation, which demonstrates its firmness and incompressibility in a striking manner. Some surgeons have tried to make use of this peculiar attribute of cancerous infiltration for purposes of early diagnosis, and especially as a means of differentiating between the results of inflammatory and malignant disease—the inflammatory cervix yielding to the dilator and becoming softened under the influence of continuous pressure. The slow method of dilatation (as by the

use of tents) seems better adapted to this purpose than the rapid divulsion with metallic instruments. The use of sulphate of copper was thought by Heitzmann to be a reliable and unfailing aid in the recognition of the incipient ulcerative form of cancer of the cervix. He applied a 10 per cent. solution of this drug to the suspected area, producing hemorrhage in beginning cancerous ulceration, and a bluish-white coating without hemorrhage in cases of simple or inflammatory erosion.

The best evidence that there is no absolutely certain method of diagnosing cancer in its earliest stages, except by the use of the microscope, is afforded by the efforts which have been and are now being made to find some change in the human organism which can be said to be peculiar to the disease. These investigations have been conducted chiefly in the fields of chemical and serological research. Perhaps the most promising serum-test is that of Abderhalden, concerning whom and whose work in the sero-diagnosis of other conditions much has been said and written in recent months. His test has for its basis the premise that when foreign proteins gain access to the circulation, the organism reacts by elaborating a ferment which causes their disintegration or digestion. The same reaction is thought to take place when certain peculiar proteins are derived from the body itself—by autogenesis, so to speak. Elements from the placenta, for example, pass into the maternal blood, and the serum has been shown to be able to digest placental tissue. This change, it is believed, occurs only in pregnancy, and therefore the test for pregnancy is based upon this principle. It has been assumed that in cancer analagous reactions occur, and the experimental digestion of cancerous tissue by the serum of suspected patients, who later have shown unmistakable evidences of cancer, has given much encouragement to those who would attack the disease in its real incipiency.

To discuss the early diagnosis of cancer naturally leads one to consider the various measures which have been proposed for the purpose of restricting or preventing it, as far as possible. Much has been said of late regarding these phases of a great and pressing problem, and I trust I may be pardoned for making reference to them before I close. For the general educational campaign now being waged under the auspices of a number of State and national organizations, both lay and professional, I have only words of commendation. The instruction of the public as to the possible significance of the much-neglected early signs of cancer is unquestionably a step in the right direction, but unfortunately the very classes of society in which cancer is most frequently to be found cannot be reached by newspapers, magazines or public lectures. I believe that the general practitioners of medicine constitute the most important agency in the instruction of the public, and if all of them would take advantage of the many opportunities which come to them to explain the possible meaning of hemorrhage, discharge and pain at or near the time of the menopause.

not only would a decided improvement in the mortality statistics of cancer be effected, but much of the pain and misery which come to them in cases of fatal procrastination would be avoided.

Going further with the duties and responsibilities of physicians I beg to quote from statements made by Dr. Howard A. Kelly and Dr. William Easterly Ashton, because they so well express the opinions which I have long held, and to which I have frequently given expression. Dr. Kelly, in his Medical Gynecology published in 1908, has this to say: "In from six to eight weeks after every confinement the medical attendant should see his patient, with the object of making a careful inspection and of noting in his case-book the extent of the traumatism caused by the labor and just what lesions remain. Every woman who has borne children should be examined by a competent physician at least once a year until she is 55 years old. The effect of an adoption of these rules would be prompt discovery of an enormous number of cancer cases in their very incipiency. That such a course would be distasteful to women at large I do not doubt but who would measure such a trifling sacrifice against the great gain of even a small increase in the percentage operability of this distressing and today largely hopeless class of cases?"

Dr. Ashton, writing in August, 1912, expresses still more pertinent and definite views in the following words: "While nothing is known of the cause of cancer, yet it is a clinical fact that the disease occurs almost exclusively in women who have borne several children, and consequently, so far as our present knowledge serves us, it is important that lacerations of the cervix should be viewed in the light of a dangerous predisposing cause. As a prophylactic measure, therefore, all such traumatisms should be repaired. This is specially true of lacerations which are associated with eversion of the mucous membrane of the cervical canal cystic degeneration, erosion and hyperplasia of the tissues of the cervix. The obstetrician before discharging a patient after confinement should examine the cervix, and if a laceration is found to be present, it should be repaired within three or four months. It should also be the duty of the general practitioner to examine the cervix of all women who consult him for pelvic symptoms and urge a repair operation if a laceration is found. And finally, I would urge, as a routine practice, the examination of every woman over 40 years of age who has borne children and the immediate repair of all lacerations of the cervix that may be discovered. The prophylactic treatment of cancer of the cervix, in my judgment, is most important, and I am convinced that the frequency of the disease could be materially lessened if the general practitioner would educate his patients to appreciate the necessity for repairing cervical tears."

Significant and suggestive as are such statements when made by men of wide experience and acknowledged ability, skill and judgment, I feel that I am fortunate in being able to give them additional value by referring to the work of another surgeon who

has recently spoken not of what *should* be done, but of what *has* been done by him along the lines indicated in the above quotations. Dr. L. M. Bossi, in the Zentralblatt für Gynäkologie of July 5, 1913, says: "The purpose of so-called prophylaxis seems to have been an early diagnosis with the object of timely hysterectomy. This is surgical therapy, not prophylaxis. The aim of gynecologists should be to find the means to prevent the development of uterine cancer. Is this possible? Twenty-seven years of clinical experience sustains an affirmative reply. Remove the predisposing chronic lesions from the cervix and cure by the curette or otherwise the hyperplastic formations of the corporeal mucous membrane. In my experience with 7000 cases in which I have performed plastic operations on the portio vaginalis, I could in none of them, even after many years, establish the development of cancer where it is concededly most frequent. I am sure that in most cases the origin of cancer is to be found in chronic lesions and inflammations (Endometritis, Endocervicitis, etc.) which have been treated in the usual dilatory way, and especially with chemical caustics, whose misuse creates serious disturbances in the tissues. The assertion that cancer has its origin in injuries or lesions, themselves benign, which are not treated in time or in a proper manner, therefore follows. A really humanitarian and clinically scientific work would be a propaganda for the prophylaxis of cancer of the uterus, the basis of which should be timely, systematic and persevering surgical treatment of benign affections of the cervix and uterine cavity."

In the preparation of a suitable address for this occasion I have encountered many difficulties and frequent interruptions. Such as it is, however, I offer it to you with my best wishes for the success and permanency of the Franklin Square Hospital Medical Association. I now have certain more or less clearly defined opinions with regard to the cancer problem which I beg to submit to you in closing. I should be glad, indeed, if by some happy thought or useful suggestion I could aid in an appreciable degree in the warfare against what has been fitly characterized as a national peril.

In my judgment, the Franklin Square, and every other public general hospital in this city and elsewhere, should maintain a well-equipped and properly conducted department of surgical pathology, open to all reputable physicians, who should be encouraged to send specimens for examination, and especially scrapings and sections from cases in which cancer is suspected. I would carry the laboratory idea further, because, for economic if for no other reasons, the organized governments of the State and city, in their respective health divisions, should also provide facilities, likewise available to all licensed practitioners of medicine, for a prompt and authoritative report upon cases of suspected cancer, as they now do so effectively in cases of tuberculosis, typhoid fever, diphtheria and other less serious ailments. Why, for example, should not the functions and duties of the State bacteriologist or

pathologist include reports upon suspected cases of malignancy, especially among the poor? Moreover, it seems to me that the medical schools, in arranging their curricula, might with advantage give greater prominence to the most advanced methods for the early recognition of tuberculosis and cancer, and that State licensing boards, against whose unpractical examinations much deserved criticism has been directed, should also place more emphasis upon these vital subjects and give greater relative credit to those who show a familiarity with them. What a stimulus this would be to the undergraduate who is preparing to "run the gauntlet" of the examining board and at the same time endeavoring to equip himself for the imminent and important problems with which he is sure to be confronted, even in the beginning of a medical career!

And finally, I desire to state in the most deliberate manner that, in my opinion, humanitarians, philanthropists, social workers and legislative bodies, with money at their command to spend or to appropriate for useful purposes, would do well to divert their attention for a while from public libraries, free drug dispensaries, spasmodic and abortive vice crusades, experimental radium institutes, societies for the promotion of the welfare of lower animals, and other more or less commendable if not always utilitarian projects, and focus it upon the poverty-burdened women of the country who are sadly in need of public maternities, where the most important function of their lives could be safeguarded and conducted with proper care, supervision and environment, in which or from which the subsequent physical welfare of mothers could receive systematic and capable attention, and under the auspices of which the *real* prophylaxis of cancer could be effectively practiced. The establishment and maintenance of nurseries for the care of the children of the poor during the lying-in period would of course be a logical and natural accessory to such institutions, and would do much to promote and facilitate their general use.

THE SURGICAL CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO. Philadelphia and London: W. B. Saunders. Baltimore: The Medical Standard Book Co. Bi-monthly. Per year, $8. December, 1913.

Here are to be found articles on the production of artificial pneumothorax by the injecting of nitrogen according to the method of Dr. Murphy, bone cyst of the radius, pyonephrosis, ununited fracture of the radius previously plated, transplantation of bone, subcutaneous abscess following tuberculosis of the spine, aspiration and injection of formalin and glycerin solution, undescended testicle in the inguinal canal, etc., and a talk on cholelithiasis and cholecystitis. Certainly this is a feast good enough for kings, and, what is more, is not the rehash of others, but what Dr. Murphy has himself seen and done.

Maryland Medical Journal

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BALTIMORE, MARCH, 1914

THE CONTROL OF CANCER.

With the advance of civilization cancer seems to be apparently on the increase. This increase is apparently a penalty of civilization. As yet in deep-seated malignancy there is only one treatment—surgical. There is no authentic report of a single visceral cancer having been cured by medicinal means. Whether this increase is real or only apparent is a difficult problem to prove, as better means of diagnostication may have played a part in directing attention to the greater prevalency. Again, the lengthening of the span of life may also be concerned to some extent in the apparent greater frequency. At any rate, the profession now thoroughly realizes that no race or age is immune; that certain periods are more dangerous than others; that if the malady is to be conquered it must be gotten early, or, better still, in the precancerous stage, by which is meant the removal of growths from those organs particularly predisposed to cancer before malignant degeneration has set in. Writing along these lines, Dr. Joseph C. Bloodgood, in a paper read before the Clinical Congress of Surgeons of North America, Chicago, November 13, 1913, sounds the clarion note: To improve the results, to increase the number of cures of cancer, there are two factors over which we have control—the duration of the disease and the treatment. Long experience and investigation seem to show that cancer never begins in healthy tissue. There is always a pre-existing local defect which is benign and in which later there may be a cancerous development. When this previous defect is situated on the skin, beneath the skin or on the mucous membrane of the lip, tongue and mouth, everyone is aware of the little lesion. These previous defects or local lesions in which cancer may develop may be called precancerous. The complete removal or complete healing of these precancerous lesions will, in Dr. Bloodgood's experience, accomplish a cure in 100 per cent. of cases; that is, none of these people will die of cancer from a growth in the situation from which the precancerous growth has been removed. Such

cases cannot be called actually cured of cancer, but we can be quite certain that such treatment prevents cancer in many, if not all of the patients treated. Little tumors which have been present since birth, or noticed later in life, may occur on the skin as warts, moles or nevi, any one of which is subject to cancerous degeneration. A wound, burn or some injury or disease may destroy the skin or mucous membrane, and not healing, a chronic ulcer results. The wound never heals, or heals badly and then breaks down; the open sore remains for weeks, months or years. At any time a cancer may develop in such ulcer. Cancer may result from some form of chronic irritation of the skin and mucous membrane which does not destroy it, as chronic inflammation about bad teeth. All of these precancerous lesions of the skin and mucous membrane are recognized by their hosts the moment they begin. Delay in treatment is due to ignorance, fear or skepticism. As previously stated, proper treatment instituted in the precancerous stage should result in 100 per cent. of cures. Any treatment which does not completely remove the little tumor or accomplish perfect healing of the ulcer is more dangerous than no treatment at all. The author's investigations over a period of twenty years with almost 3000 cases demonstrates that in cancer in accessible regions good surgery in the precancerous stage should accomplish 100 per cent. of cures, because this early recognition and treatment leads to the complete eradication of the precancerous lesion still benign, or to the recognition of the earliest stage of cancer by the microscopic study of the piece excised, and thus leads to the radical operation indicated at a period most favorable for the cure of cancer. The above dictum also applies to precancerous lesions of the internal viscera, though with the present means at our command these are harder to detect. Certainly here their early eradication would go a long way toward the reduction of cancer incident to the abdominal viscera.

Though much is known about cancer, still much remains to be learnt, and until we are better informed concerning the etiology, the teachings of Dr. Bloodgood are certainly sound. Here, as in other lines of endeavor, an ounce of prevention is better than a pound of cure. A bad-looking mole removed, perhaps a cancer victim saved. Briefly, the only hope the profession has at present of reducing the prevalency of cancer is to educate the populace to the possible danger lurking in lesions prone to undergo cancerous degeneration and advise early and complete eradication. This is Dr. Bloodgood's lesson.

Medical Items.

Official announcement was made January 10 at Johns Hopkins Hospital of the new appointments to the staff for the year beginning September 1. These appointments are made from the graduating class of next June and are coveted plums among the seniors. Two women are included in the list.

The appointments and services are as follows:

Medicine— F. A. Evans, S. Bayne-Jones, J. T. King, Jr., and Miss A. Clark.

Surgery—G. R. Dunn, J. K. Ormond, J. P. Webster and I. Zadek.

Gynecology—Dr. G. W. Corner, L. H. Redelings and H. M. N. Wynne.

Pediatrics—G. A. Batten, M. Flexner and Miss A. S. Rothholtz.

Phychiatry—J. C. Donaldson.

Obstetrics—Dr. D. Davis and J. Webb.

Throat—C. E. Connor.

Dr. J. McPherson Scott has announced the names of those to whom the State Board of Medical Examiners, of which he is secretary and treasurer, has ordered licenses issued as the result of the examination held in December. They are: Clement M. Arnold, Alfred W. Brown, Chas. McT. Campbell, James E. Diehl, William W. Dumm, Samuel E. Enfield, Lyman W. Gaylord, Harry Goldsmith, F. M. Gottschall, Augustus C. Gray, W. Frank Gemmel, Arthur L. Hichew, Leon S. Horka, Garrett L. Hynson, Bernard V. Kelly, Ernest G. Marr, Simon C. Neistadt, Walter Price, Solomon Reina, T. E. Sass, William H. J. Scruggs, Thomas S. Shepperd, Loyal A. Shoudy, Boylston D. Smith, Joseph Sparck, John C. Stansbury, Henry A. Stephenson, John E. Thomas, Cleveland D. Whelchel, Zachariah W. Wyatt.

Dr. William H. Welch of Johns Hopkins University was the chief orator at the installation of Dr. C. R. Holmes as dean of the medical department of the University of Cincinnati, January 16.

Dr. Henry Barton Jacobs, president of the Maryland Society for the Prevention and Relief of Tuberculosis, and Miss McKay Jones, head tuberculosis nurse of the City Health Department of Baltimore, addressed a meeting held in the interest of the cause in the House of Delegates chamber at Annapolis on January 16.

Drs. Randolph Winslow, Frank I. Martin and J. M. T. Finney attended the 26th annual meeting of the Southern Surgical and Gynecological Association Convention in Atlanta, Ga., December 16-18, 1913. Dr. Finney read a paper on cancer, which was received with much enthusiasm.

Dr. S. T. Nicholson, Jr., superintendent of Sydenham Hospital, has resigned his position, to take effect March 15.

Dr. Carl von Noorden, Jr., and Dr. George Minot have been appointed to the Johns Hopkins Hospital Staff.

An X-ray department and pathological laboratories have just been concluded at the Church Home and Infirmary, both of which improvements were badly needed. Especially is this true of the X-ray department. Formerly patients at the hospital who had to undergo X-ray treatment were obliged to go to Johns Hopkins Hospital for it.

Dr. John I. Macht, Johns Hopkins Medical School, '06, of 1511 Madison avenue, has been re-elected president of the Jewish Academicians of Baltimore.

A fire in the office of Dr. Myer W. Aaronson, 1710 Linden avenue, caused damages estimated at more than $1000.

A maternity hospital, completely furnished, has been given as an adjunct to the Hebrew Hospital and Asylum by Abraham Mendels, a retired merchant of this city, as memorial to his two late brothers. Work on the building will begin immediately.

At the regular semi-annual meeting of the Prince George's County Medical Society, held Saturday, January 10, 1914, the following officers were elected for the year 1914:

President—H. B. McDonnell, M.D., Physicians and Surgeons, '88, College Park, Md.

Vice-President—J. C. Coggins, M.D., Physicians and Surgeons, '96, Laurel, Md.

Secretary—S. M. McMillan, M.D., Howard University School of Medicine, Washington, D. C., '90, Riverdale, Md.

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Dr. Charles Bagley, Jr., University of Maryland Medical School, '04, announces that he has resumed practice in Baltimore. He is located at 5 W. Chase street. For the past year

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Dr. Bagley has been first assistant to Dr. Harvey Cushing, chief surgeon of the Peter Brent Brigham Hospital at Boston, Mass.

Dr. John B. Bay, secretary of the American Otological Society, announces that the annual meeting of the organization will be held at the Hotel Chelsea, Atlantic City, N. J., May 27 and 28, 1914.

Dr. Lewellys Franklin Barker, Professor of Medicine, Johns Hopkins University, of 1035 Calvert street, Baltimore, Md., has been elected one of the directors of the Alpha Omega Medical Scholarship Society.

The 1914 annual session of the American Medical Association will be held at Atlantic City during the fourth week in June. The House of Delegates will convene Monday, June 22nd, and the Scientific Assembly, Tuesday, June 23rd.

The following are the officers of the local Committee on Arrangements: William Edgar Darnall, chairman; E. C. Chew, treasurer, and Henry T. Harvey, secretary.

The chairmen of sub-committees are: Finance, George Scott; Entertainment, William J. Carrington; Section Entertainment, W. E. Jonah; Hotels, Thomas D. Taggart; Halls and Meeting-Places, Walt P. Conaway; Section Meeting, Byron G. Davis; Programs, C. Coulter Charlton; Printing, Walter Reynolds; Badges, E. H. Harvey; Scientific Exhibit, I. E. Leonard; Registration, William Martin; Information, Richard Bew; Alumni Entertainments, Joseph C. Marshall; Post-Office and Telephones, C. Garrabrandt; Commercial Exhibit, E. Guion; Ladies Committee, Mrs. E. H. Harvey.

MARRIAGES.

Branch Craige, M.D., University of Maryland Medical School, '09, to Miss Else Betty Kohlberg, both of El Paso, Tex., at El Paso, January 21, 1914. After a short wedding trip, Dr. and Mrs. Craige will reside in El Paso, where the groom is practicing his profession.

William Edwin Gallion, Jr., M.D., University of Maryland Medical School, '12, of Darlington, Md., to Miss Sarah R. Rites of Arlington, Md., at Danbury, Conn., July 25, 1913. Dr. Gallion was a resident physician at the University Hospital from 1912-1913.

Charles Willis Larned, M.D., University of Maryland Medical School, '93, to Miss Cornelia Lee Pattison, both of Baltimore, Md., at Baltimore, February 2, 1914. Dr. Larned is an instructor in the Johns Hopkins Medical School and a member of several leading clubs.

James B. Holmes, M.D., of 13-15 E. Read street, to Miss Rosalie Seddon Rutherfoord of Roland Park, at Baltimore, Md., January 31, 1914.

Charles E. Clark, M.D., of Olean, N. Y., formerly house physician at the Maryland Homeopathic Hospital, Mount street, Baltimore, Md., to Mrs. Rosa A. Baum of Baltimore, at Baltimore, January 19, 1914. Dr. Clark graduated from the Hahnemann Medical College, Chicago, Ill.

Charles Birdsall, M.D., Physicians and Surgeons, '83, to Miss Myrtle Wilkes, both of Lonaconing, Md., at Lonaconing, January 21, 1914.

Clarence Irving Benson, M.D., University of Maryland Medical School, '09, of Port Deposit, Md., to Miss Mattie E. Benson of Philadelphia, Pa., at Philadelphia, February 11, 1914. Dr. and Mrs. Benson will spend their honeymoon in Bermuda.

Charles Alan Laubach, M.D., professor of hygiene and bacteriology at Johns Hopkins Medical School, to Miss Natalie Trotter Usher of Baltimore, Md., at Baltimore, December 17, 1913.

Joshua Rosett, University of Maryland Medical School, '05, to Miss Louise Carey, both of Baltimore, Md., at Ronceverte, W. Va., February 7, 1914.

DEATHS.

Thaddeus W. Clark, M.D., University of Maryland Medical School, '80, of 10 W. Hamilton street, died at the home of his brother-in-law, 58 W. Biddle street, February 14, 1914.

Mrs. Sophia Thayer, mother of Dr. William S. Thayer, professor of clinical medicine, Johns Hopkins Medical School, of 406 Cathedral street, died at her home in Cambridge, Mass., January 24, 1914, after a lingering illness.

Mrs. Viola Struven Fehsenfeld, wife of Dr. Arthur L. Fehsenfeld, University of Maryland Medical School, '09, died of blood poisoning at her home, Garrison and Fairview avenues, Forest Park, February 6, 1914. Dr. Fehsenfeld is assistant in neurology at the University Medical School.

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Correspondence.

Battle Creek, Mich., January ——.

Four hundred men and women of prominence, comprising the first representative group of scientific experts ever gathered in America for that purpose, met in Battle Creek January 8-12 to assemble evidence of race deterioration and to consider methods of checking the downward trend of mankind. The meeting was known as the First National Conference on Race Betterment. Through the co-operation of the press, the objects and aims of the conference have been very widely disseminated, and a resultant influence for better race ideals is anticipated.

Already the effect of the conference is apparent in Battle Creek, where popular interest in mental and physical efficiency was awakened by a series of public school tests, which showed an alarming percentage of defective children in all grades.

The conference had its inception in the efforts of four men particularly interested in race betterment—Rev. Newell Dwight Hillis, pastor of Plymouth Church, Brooklyn, N. Y.; Dr. J. H. Kellogg of the Battle Creek Sanitarium; Sir Horace Plunkett, former minister of agriculture for Ireland, and Prof. Irving Fisher of Yale University. At the invitation of a central committee chosen largely by these men, fifty men and women of national prominence in the fields of science and education consented to share in the program. Their addresses, together with open discussion of many of the points considered, constituted a very widespread study of all phases of evident race degeneracy and the advocacy of many ideas of reform. Some of the suggested methods of improvement are frequent medical examination of the well, outdoor life, temperance in diet, biologic habits of living, open-air schools and playgrounds, the encouragement of rural life, the segregation or sterilization of defectives, the encouragement of eugenic marriages by requiring medical certificates before granting license, and the establishment of a eugenics registry for the development of a race of human thoroughbreds.

Among those having a share in the program were Rev. Newell Dwight Hillis, Jacob Riis, Judge Ben B. Lindsey, Booker T. Washington, Dr. Victor C. Vaughan, Dr. S. Adolphus Knopf, Dr. C. B. Davenport, Dr. J. N. Hurty, the Very Rev. (Dean) Walter Taylor Sumner, and many others of equal prominence.

Some of the interesting statements of the conference are summarized as follows:

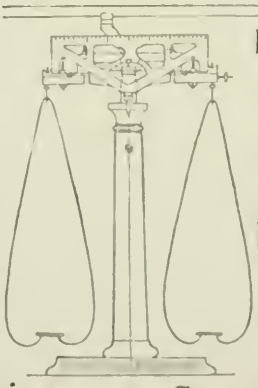
It will be no easy task to improve the race to the point where there will be no dependent children, but the elimination of the dependent child will be one of the best indices of the superiority of our national stock.—*Dr. Gertrude E. Hall, New York State Board of Charities.*

I believe that a great deal can be done by publication of facts as to the physiological effects of alcohol, in the way of inducing educated and intelligent people to conserve their health by limiting the use of alcohol or giving it up altogether.—*Henry Smith Williams, Author.*

Eugenics does not eliminate romance. We eugenists believe romance should be retained. Through the past it has proved a good thing.—*Prof. Roswell H. Johnson, University of Pittsburgh.*

In order that the race may survive it will apparently be necessary to make a eugenic selection of healthy mothers and to provide that the cost of bearing and rearing children shall be equally shared by all.—*Prof. J. McKeen Cattell, Editor Popular Science Monthly.*

The boys are learning that they have a calling just as sacred as the call



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to motherhood, and that is the call to fatherhood."—*The Very Reverend (Dean) Walter Taylor Sumner of Chicago.*

The negro in the South, with all his weaknesses and handicaps, is not yet in any large measure in the ditch.—*Booker T. Washington, Principal of Tuskegee Institute.*

We must cultivate pure blood instead of blue blood if we would develop a race of human thoroughbreds.—*Dr. J. H. Kellogg, Superintendent Battle Creek Sanitarium.*

Abstracts.

PRESIDENT'S ADDRESS—PROCTOLOGY AND PROCTO-ENTEROLOGY.

By Louis J. Hirschman, M.D., Detroit, Mich.

Read before American Practologic Society, June 16-17, 1913.

He stated that, "Proctology come into its own," is in reality the study of the entire intestinal tract, its diseases and their remedies. A proctologist becomes skilled to a high degree in the medical and surgical treatment of the diseases of the lower bowel. A medical practitioner sufficiently skilled and competent to treat diseases affecting any portion of the intestinal tract should be competent to treat all portions. The modern proctologist, therefore, must be an intestinal surgeon. He must have knowledge of modern views and discoveries bearing on the digestive tract, as they have a direct bearing on intestinal function and pathology. He should no more limit his activities to the rectum and sigmoid alone than does the laryngologist to the larynx, or the urologist to the urethra.

An arbitrary line of division which limits a specialist's activities to the lower six or eight inches of the colon is absurd. The proctologist has no moral right to withhold his special skill in intestinal surgery from the patient who suffers from diseases of the small intestine or upper colon. The larger problems of intestinal stasis, chronic inflammatory conditions, and malignant diseases of the small and large intestines, demand the best that is in every fellow of our organization. He should ever study and fathom out the problems of etiology, pathology and proper therapy.

The establishment of a section on gastro-enterology and proctology in the American Medical Association would greatly increase the value of that organization to every one of its members who comes in contact with diseases of the alimentary tract.

It is the American Medical Association which should foster all that is new and valuable in medicine. It is the greatest medical educational institution in our country; and the fellows of the American Proctologic Society should be the most enthusiastic supporters of such a section, if established.

REPORT OF A CASE OF FECAL TUMOR ASSOCIATED WITH HIRSCHSPRUNG'S DISEASE.

By Alois B. Graham, A.M., M.D., Indianapolis, Ind.

Read before American Practologic Society, June 16-17, 1913.

Dr. Graham reported a case of fecal tumor associated with Hirschsprung's disease, a clinical history of which is unique and exceedingly interesting. The patient, a young French woman,

Over-feeding of fat is often responsible for constipation in bottle-fed infants

This condition is of course best corrected by removing the cream from the milk used in preparing the infant's diet.

Such a reduction in total solids, however, must be compensated for or the infant will lose weight. This loss is readily made up by adding to the mixture Mellin's Food in increased amounts, thus assuring ample calories for a proper gain in weight.

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aged 27, stated that she had undergone three abdominal operations for Hirschspring's disease, or megacolon.

Present illness dates from birth. Not unusual to go a week or 10 days without a stool, and then evacuation was produced only by means of enemata.

At the age of 12 her condition was diagnosed as one of pregnancy on account of the vomiting and the appearance of the abdomen.

At the age of 19 she suffered an attack of complete intestinal obstruction, due evidently to fecal tumor. She was operated, and a large fecal tumor was removed from the sigmoid. Six months later she was operated for post-operative adhesions. No resection of the bowel or short-circuiting operation was performed.

At the age of 25 she suffered an attack of complete intestinal obstruction. She was operated, and a large fecal tumor was removed. Patient stated that the bowel was plicated in closing. Wound healed promptly, but she remained in the hospital for three months purely for clinical purposes.

August, 1912, she, for the third time, presented symptoms of complete intestinal obstruction. She had been absolutely constipated for seven days. Abdomen enlarged and everywhere tympanitic, except in the lower right quadrant, where there was a dull area corresponding to a large tumor which could be readily palpated. Tumor, a fecal mass, was exceedingly hard, and did not pit on pressure. It could be easily moved in every direction throughout the abdomen. Attacks of violent, colicky pains were frequent. Vomiting was persistent, pulse 120, temperature 101 F. Hydrogen peroxide, introduced into the rectum, had no effect on the tumor, but produced excruciating pains over the entire abdomen. Patient consented to operation, with the promise exacted that nothing radical be attempted. She requested that the fecal tumor be removed, but refused to give her consent to any short-circuiting or resection of the bowel.

Median incision. No adhesions. Fecal tumor in sigmoid. Tumor of "stony" hardness. Its greatest circumference was 19¾ inches, its weight was 64 ounces. The dilatation which was confined to the sigmoid was very marked, the greatest circumference being 20 inches.

Patient made an uneventful operative recovery, and was discharged from the hospital on the tenth day. She gained in weight, and appeared to be in the best of health. She experienced no difficulty in procuring daily evacuations with the aid of small doses of cascara.

December 15, 1912, was the date of her last visit to the writer's office. At this time she was doing nicely. Inquiries as to her whereabouts were made, and the reports were to the effect that she has returned to France. Information was received the latter part of April that patient had gone to Chicago from Indianapolis. She evidently suffered another attack of intestinal obstruction. She was operated there April 19, 1913, and died three days later.

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A METHOD OF OPERATING ON FISTULA WITHOUT CUTTING MUSCULAR TISSUE.

By Rollin H. Barnes, M.D., St. Louis, Mo.

Read before American Practologic Society, June 16-17, 1913.

This method is used in those cases of fistulæ which involve the sphincter muscles. An incision is made external to the sphincter, similar to that made when incising an ischio-rectal abscess. Through this opening the scar tissue is dissected out up to the internal opening. An incision is then made at the skin margin, so that the middle of this incision passes through an imaginary longitudinal line drawn from the internal opening. A submucous dissection is then channeled out up to the internal opening. Gauze drainage is kept in this until the external wound is healed sufficiently. Then the submucous tract, which remains, is incised under local anesthesia. No muscular tissue having been cut, the function of the sphincters is preserved intact.

Z-PLASTIC OPERATION FOR ANAL STRICTURE.

By William M. Beach, M.D., Pittsburgh, Pa.

Read before American Practologic Society, June 16-17, 1913.

The writer states that extensive cicatrices, resulting from trauma, and involving the partial or entire anal circumference, not infrequently resist the usual methods employed to restore the physiologic function of the anus.

He, therefore, employed what he terms a Z-plastic method when operating on an anal stricture. The principle underlying the procedure is the transposition of dermic tissue in such manner as to obliterate the crest of the fibrous band.

The first incision is made along the crest of such a band; then incisions are made at right angles from both ends, but running in opposite directions, thus approximating the letter Z. The flaps thus outlined are dissected up, transposed and sutured. Various modifications are permissible, according to the extent of the stricture.

SPHINCTERIC ATROPHY—CAUSES, CONSEQUENCES AND TREATMENT.

By Ralph W. Jackson, M.D., Fall River, Mass.

Read before American Practologic Society, June 16-17, 1913.

Muscular atrophy about the anus produces more serious consequences than hypertrophy.

The physiology of defecation is studied, and the action of the internal sphincter and of the external sphincter and levators sharply contrasted with their different innervation. This is preparatory to consideration and classification of the causes of sphincteric disuse and consequent degeneration.

Congenital causes are found in imperforate anus and congenital ano-vaginal cloaca. Coincidental with general weakness cases occur in infants, the aged and the extremely ill. Traumatic causes are faults of proctologic operations and after-care, or obstetric lacerations, or due to prolonged divulsion by protruding

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piles or procidentia. Nerve causes are primarily sympathetic as in rectal stenosis, or central as in spinal cord lesions.

Degeneration or absence of one sphincter without impairment of the other is considered.

The unhappy consequences of sphincteric inadequacy are presented.

Treatment is preventive or restorative. Neither avails much when due to nerve causes, except possibly in luetic cases. Of first importance is the minimizing of trauma, both obstetric and proctologic (especially sphincteric incision). Repair of trauma should be immediate and accurate. Later attempts are much more difficult and uncertain on account of atrophic muscular changes, and often results must depend on cicatrical contraction and adaptation of other muscles, especially the levators, to sphincteric duty. Restoration of long-overstretched muscles is largely dependent on general treatment.

Sphincteric deficiency is a troublesome problem to every practitioner, and the prognosis is uncertain.

C. W. POST.

(The same being a few lines dedicated to a pal.)

Some envy you your millions, some envy you your fame,
Some envy you the buildings great on which is carved your name;
Some envy you your luxuries and some your great success,
And some the force for doing things which you today possess.
But I—I saw a young man gaze at you as you passed by
And O, I envy you the look that lit that youthful eye.

I do not envy you your chance to give in large amounts;
When all is said and done it's not the size of gifts that counts;
I do not envy you because you own this building fine,
I might not be a better man today if this were mine.
But did a young man look at me in such a grateful way
As I have seen one look at you, I'd happier be today.

I do not envy you your wealth, I might gain that and more
And still not have one single friend come smiling to my door;
A man might climb the topmost heights of fame and stand apart
The cleverest one of all the age—and be a cad at heart.
I envy no man's skill, but Oh, I'll say to you tonight
I envy you the grateful look that made that boy's eyes light.

I envy you his smiling face, his kindly thoughts of you,
I envy you the splendid deeds that some day he will do;
For in his eyes, I read of you, not sordid gifts of gold
For which, so oft, the taker finds his manhood he has sold
But kindness in a larger sense, above all place and pelf,
I envy you the chance you gave that youth to help himself.

I have no wish to leave behind great monuments of stone,
I'd rather leave my finger prints on living flesh and bone.
I'd rather leave but one behind, who, when I've gone, shall say;
"He helped me up to better things, he smoothed my troubled way."
If only one speak thus of me, I shall not fear to die,
And so tonight I envy you that look as you passed by.

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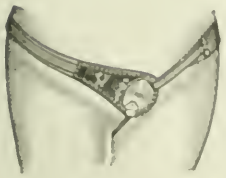

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

The Great Practical Advance in Serotherapy and Immunization by Means of Serobacterins.

SEROBACTERINS are sensitized bacterial vaccines or suspensions of killed sensitized bacteria. In the language of the laboratory, they are produced by saturating bacteria with the specific antibodies found in the serum of an immunized animal, removing the excess of serum by centrifuging and suspending the bacteria in a saline solution. According to the trustworthy reports of bacteriologists and clinicians, they are destined in great measure to supplant other means of immunizing against and treatment of many infectious diseases.

The method of sensitizing is, in brief, the treatment of killed bacteria with specific immune serum whereby the bacteria unite with the immune bodies present in the serum, so that upon injection the combination is ready for immediate attack by the "complement" in the patient's blood.

There is thus secured a great gain of time over the older methods of bacterial therapy, and whether in prevention or treatment, this immediacy is of the utmost value. In a few days, for instance, by typho-serobacterin, the practitioner may now secure for his patient im-

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munity against typhoid as formerly in nearly a month with the old typhoid vaccine.

Other advantages are that there is no local irritation at site of injection and little or no lassitude or sickness. More important, still, is the fact that there is no negative phase. The size of the doses may also be greatly increased, even quadrupled, thus assuring rapidity of production and strength of immunity.

Of interest in this connection are the laboratory results of Theobald Smith and the work of Von Behring in combining diphtheria toxin and antitoxin for immunization against diphtheria. By making mixtures containing varying amounts of toxin and antitoxin they were able to secure any degree of immunity—from a short passive immunity due to the serum, to an active immunity of long duration, resulting from the action of the toxin.

To the foregoing advantages of the uses of serobacterins it may be added that in very late stages of the disease, when the bacterial vaccines and even serum treatment is ineffective, successful results are sometimes obtained and life is saved.

Besredka, of the Pasteur Institute, authoritatively summarizes the matter by saying:

"Whatever the nature of the virus, whether the microbe of plague, dysentery, cholera or typhoid fever, or whether the virus of rabies or the toxin of diphtheria, whether the microbes are killed or living, sensitization confers upon them properties which convert them into vaccines of the first order, possessing an action which is sure, rapid, ineffensive and durable."

The results of the clinical use of serobacterins in actual practice give, of course, the final and convincing test. Of such reports one [illegible] of Cannes on the [illegible] of streptococcus bacterial vaccine [illegible] that when the resistance did not exceed a [illegible] the highest figure that [illegible] in the case of epidemics should have a [illegible] future than to compare the resistance of the patients only be raised to [illegible] sensitized vaccines or the immunizing [illegible] operations on the abdominal cavity or [illegible] tected areas, in preventing secondary infections and possibly in cases of [illegible] He says that in cases already operated, the evidence shows that only a proportion of [illegible] it is possible by this method to promote materially the patient's recovery. He recommends using a sensitized vaccine in these patients as appear to bring into action available reserves in that complex and still inadequately known entity, the patient's specific resistance.

As to the dosage, Gordon, as empirical, says as the first dose 500 million, 24 hours later the second dose was 1000 million, the third, at 24 hours, was 2000 million.

Broughton-Alcock found that in acute and chronic gonorrheal urethritis the injections were of little value, but that good results were almost invariable in gonorrheal orchitis, epididymitis, arthritis and periarteritis, tenosynovitis, acne, furunculosis, iritis, [illegible] rheic eczema.

Boinet found that the good results in typhoid fever were in accordance with the nearness to the beginning of the infection, diminishing the gravity and shortening the duration of the disease.

In gonorrhea Cruveilhier found that in all cases the duration of the disease was notably modified, in acute gonorrheal rheumatism he reports a number of cures. In chronic gonorrheal rheumatism and muscular [illegible] results are reported.

Speaking generally, sensitized vaccines give active immunity within 24 hours after the first injection, with marked improvement in the patient's condition. They produce no opsonic or clinical negative phase and therefore will do away with the necessity of subjecting the patient to the ordinary bacterial vaccines in use.

To insure that the introduction of properly sensitized bacterial complement combinations are carried out in accordance the extent of antibody formation to the bacteria. As a further safeguard against [illegible] are detected and the action of the mechanism is followed by means

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of a series of tests made with the blood serum of the treated animal.

Great care is advisable in the selection of a sensitized vaccine, or serobacterin—the product only of that manufacturer should be chosen of the highest professional character.

A complete review of the Literature on Serobacterins appears in the *Mulford Digest* for December, and we suggest that those who have not received a copy of this issue request one, to be read and kept on file for future reference.

The Relief of Headaches.

One of the reasons that make Pasadyne (Daniel) particularly suitable for use in headaches and neuralgia is its freedom from danger. Not only this, but, furthermore, its employment does not subject the patient to the jeopardy of drug addiction. Pasadyne (Daniel) is merely a distinctive name for the most potent concentrated tincture of passiflora incarnata at the profession's command. Use it in headache and neuralgia and note its effect. A sample bottle may be had by addressing the laboratory of John B. Daniel, Atlanta, Ga.

The Therapy of Chronic Coughs.

THE logical therapy of chronic coughs does not lie in the use of soothing expectorants, whose main purpose is the blunting of the mucosa's sensibility and which do not really help the bronchial tree free itself of the cough's cause. Such treatment is palliative.

The logical treatment of chronic coughs embraces the continued use of a tissue food which will enable the system to throw off a cough—Cord. Ext. Ol. Morrhuae Comp. (Hagee), for instance. Cod-liver oil in the form of this cordial quickly demonstrates its marked value in this condition.

Gold Medal to Armour.

The Seventeenth International Congress of Medicine, London, August, 1913, awarded to Armour a gold medal, the highest award in the class, for Digestive Ferments (Pepsin and Pancreatin). We present photographs of the two sides herewith.

The medal is a handsome one; it represents the acknowledgment of the jury selected by this great scientific body of men that Armour's Pepsin and Pancreatin were of such quality as to entitle them to the highest award, a verdict that bears out the statement made by headquarters that Armour's Pepsin is the best product of the sort.

New Catalogue.

W. B. SAUNDERS COMPANY, publishers of Philadelphia and London, have just issued an entirely new eighty-eight-page illustrated catalogue of their publications. As great care has evidently been taken in its production as

in the manufacture of their books. It is an extremely handsome catalogue. It is a descriptive catalogue in the truest sense, telling you just what you will find in their books and showing you by specimen cuts the type of illustrations used. It is really an index to modern medical literature, describing some 250 books, including 30 new books and new editions.

A postal sent to W. B. Saunders Company, Philadelphia, will bring you a copy—and you should have one.

A NEW departure in the medical field has recently been established by Gilbert L. Smith, M.D., who won his spurs not only in this country, but in the Alaska-Canada Survey. Dr. Smith has been connected with several institutions in New York and Connecticut that pay special attention to patients suffering from the drug habit and nervousness. He has recently established a bureau, giving special attention to patients who desire to travel, and is forming a chain of sanatoriums acting as a sort of clearing-house, so that when called in consultation he can select an institution that has facilities for taking care of special patients. Dr. Smith arranges tours to all parts of the world, taking entire charge of the routing of patients, attendants, tickets, etc. This new departure will be welcomed by the medical profession of the country, as the average practitioner, while well informed as to the care of the sick, many times is not informed as to the facilities of many of the large hospitals and sanatoriums for taking care of patients.

Dr. Smith can be reached at Stamford, Conn.

Corpus Luteum is one of the organotherapeutic agents that can be supplied in limited quantities only. The amount of raw material from which it is made is comparatively small, but the physician wants a pure article. Armour & Co. state that in their laboratory the portion of the gland bearing the yellow bodies is carefully cut away and trimmed. This insures as pure a preparation as is possible until the active principle is found and isolated.

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Antiquity of Milk as a Food.

FROM time immemorial milk has been used as a food. It was necessary for the nomad tribes of Southern and Eastern Europe and Central Asia to have a milk preparation that could be carried and used on long wanderings. This they procured from mare's milk and called kumiss. Herodotus gives an account of it as used by the Scythians and Virgil sings of a tribe who drank of it—*Hippace Dahae et Hippemolgi Galactophagi* (Dahae of the Horses' Teats, Milk-drinkers).

Pioneer.

As a result of the newspaper notoriety given bichloride of mercury poisoning cases, there is a country-wide agitation regarding the sale of tablets containing this substance. It is a dangerous poison and one that should be surrounded with every safeguard to prevent accidental misuse and error. That evidently was the idea in mind when Diamond Antiseptics were placed on the market nine years ago. These tablets were pioneers, naturally, there and have continued to minimize the dangers to

users of bichloride ever since. Diamond Antiseptics render legal exactions unnecessary. The talk of legislation and restrictions that led other manufacturers to offer in lieu of mercury tablets of special design supplied on special entreaty, so that a signature of any kind is needed all they should be, it would seem, to prohibit the sale of tablets of mercury in tablet form in the form of the ordinary round or cylindrical mushroom tablet. The original Diamond Antiseptic tablets were and are Diamond Antiseptics. Lilly.

The Unrest of Acute Infection.

It frequently happens that one of the most pressing symptoms of an acute infection is a state of marked restlessness. A sense of muscular aches or pains, a feverish condition, a [illegible] which although administered in small doses may be relied upon to quiet the [illegible] nervous system and secure for the [illegible] patient the rest he so earnestly needs.

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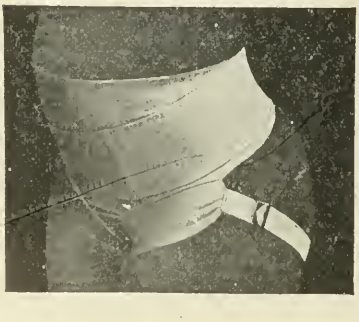

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